STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445214	A. BUILDING _____ B. WING _____	C 01/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN CITY CARE & REHABILITATION CENTER	919 MEDICAL PARK DRIVE MOUNTAIN CITY, TN 37683

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy and interview, the facility failed to provide a physical therapy evaluation in a timely manner for one (#1) of five residents reviewed. The findings included: Resident #1 was admitted to the facility on December 11, 2010, with diagnoses including Displaced Left Proximal Humerus (upper arm) Fracture, Hypertension, Gastrointestinal Reflux Disease and History of Right Total Hip Replacement. Medical record review of the initial physician's orders dated December 11, 2010, revealed orders for physical therapy to evaluate and treat. Medical record review of the Minimum Data Set dated December 18, 2010, revealed the resident required extensive assistance with bed mobility and limited assistance with transfers. Medical record review of physical therapy notes revealed the Physical Therapist evaluated the resident on Monday, December 15, 2010, (four	F 406	**F406** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #1 received physical therapy evaluation on Monday December 15, 2010. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Rehab Service Manager will conduct 100% audit of all therapy evaluation orders for past 3 months to identify any other residents affected by deficient practice. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.** Facility evaluation policy was revised by Rehabilitation Services Corporate Director of Education and Program Development and Regional Clinical Consultant to include handling of therapy evaluations during inclement weather and conditions beyond facility control. Inservice training will be provided by Director of Nursing, Assistant Director of Nursing, or Rehab Services Manager to all Full Time, Part Time and PRN Therapy Staff, LPNs and RNs. Facility has no agency staff. In case of inclement weather or condition beyond facility control physician will be notified and additional order obtained if applicable **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place?** Rehab Services Manager will develop and implement monitoring form which will track all	02/18/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dana Branch — TITLE: Administrator — (X6) DATE: 1/19/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 406	Continued From page 1 days after admission to the facility) and established a treatment plan of five times per week for thirteen weeks. Review of the facility's policy for "Rehab Evaluation" revealed, " ...Evaluations will be initiated within 1 business day of referral to therapy ..." Interview on January 5, 2011, at 9:55 a.m., in the conference room, with the Rehab Director confirmed a delay in the physical therapy evaluation being completed and confirmed the facility's policy to evaluate the resident within one business day of referral was not followed. C/O #27210	F 406	new therapy evaluation orders to ensure timeliness which will be completed by Rehab Services Manager on a daily basis. Rehab Services Manager will review results during Process Improvement Committee meeting monthly	